

North Carolina Medicaid — FOCUSED RISK MANAGEMENT PROGRAM (Page 1)

Patient Medication Profile*

Patient Information

Patient Name: _____	Medicaid ID#: _____	Date of Birth: _____
Primary Care Physician Name: _____	Prescriber Phone: _____	Prescriber Fax: _____
Pharmacy Name: _____	Pharmacy Phone: _____	Pharmacy Fax: _____

Is the patient known to be allergic to any medications? ☐ Yes ☐ No; If yes, please list: _____

Medication Profile: Complete all information for each line. Include all medications the patient is taking, including known OTC, Herbal, and non-routine (e.g., PRN) products. If necessary, additional pages may be attached.

	Start Date	Medication Name/Strength/Quantity	Regimen(dosage/route/times per day)	Purpose for use(Diagnosis if available)	Prescribing Physician and contact information	Precautions/Warnings	Stop date
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							

Date Prepared: _____ RPh Reviewer: _____

* Pharmacy may substitute their computer generated profile if it contains all of the required information listed, including medication related diagnosis.

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North Carolina Medicaid —FOCUSED RISK MANAGEMENT PROGRAM (Page 2)

Medication Review Communication Form

TO: (Primary Care Physician): _____

Fax: _____

Date: _____

Phone: _____

From: (Pharmacy): _____ Phone: _____ Fax: _____

Patient Name: _____

Medicaid ID #: _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. **Please provide a response for every recommended action.**

Medication Related Issues Identified

Recommended Plan of Action

PCP Response and Comments

<input type="checkbox"/> Medication Dose/Frequency/Duration	1.	1. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Adverse Drug Event	2.	2. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Therapeutic Duplication	3.	3. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Drug/Drug Interaction	4.	4. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Drug/Disease Interaction		
<input type="checkbox"/> Drug/Food Interaction		
<input type="checkbox"/> Discontinued Medication		
<input type="checkbox"/> Medication Compliance		
<input type="checkbox"/> Contraindication		
<input type="checkbox"/> Drug Allergy		
<input type="checkbox"/> Other; _____		

Cost-Effective Recommendations

<input type="checkbox"/> Dose Consolidation	1.	1. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Dose Optimization	2.	2. Accept Recommendation <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
<input type="checkbox"/> Generic Alternative		
<input type="checkbox"/> Other; _____		

Patient Specific Education Provided: _____

Comments: _____

Time Spent with Patient: _____ Scheduled plan for follow-up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: _____ RPh Reviewer: _____

Date: _____ Primary Care Physician: _____

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